

CERTIFICATE OF DEATH

00714
191

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Highland Manor Nursing Home</u>		d. STREET ADDRESS <u>3539 Juneway</u>	
3. NAME OF DECEASED (Type or print) First <u>Constanty</u> Middle <u>Benicewicz</u> Last <u>(Benesch)</u>		4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/23/1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailoring Co.</u>	9. AGE (In years last birthday) <u>77</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs Lillian T. Blair</u> Address <u>Route 2, Box 237A Glen Burnie Md.</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>420.0</u> (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Heart Dis. Arter. Renal Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1/10</u> , 19 <u>56</u> , to <u>1/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>57</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Leo J. Miller</u>	ADDRESS (Street, city or town, state) <u>5226 Balto Nat Pike</u> DATE SIGNED <u>1/22/57</u>	
PHYSICIAN'S NAME (Type) <u>MAX D. MILLER</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/24/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Russian Orthodox Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Brown</u> ADDRESS <u>901 Hollins St.</u>		24a. REC'D BY REGISTRAR <u>J. E. Dougherty</u> DATE <u>JAN 24 1957</u>	24b. REGISTRAR'S SIGNATURE

RECEIVED
JAN 24 1957
BUREAU V. S.

RECEIVED

BUREAU V. S.

JAN 24 1957

1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. CAUSE OF DEATH	
5. SEX		6. AGE	
7. OCCUPATION		8. MARITAL STATUS	
9. EDUCATION		10. RELIGION	
11. SOCIAL SECURITY NUMBER		12. DATE OF BIRTH	
13. PLACE OF BIRTH		14. DATE OF ENTRY INTO COUNTRY	
15. DATE OF DEPARTURE FROM COUNTRY		16. DATE OF ARRIVAL IN COUNTRY	
17. DATE OF DEPARTURE FROM COUNTRY		18. DATE OF ARRIVAL IN COUNTRY	
19. DATE OF DEPARTURE FROM COUNTRY		20. DATE OF ARRIVAL IN COUNTRY	
21. DATE OF DEPARTURE FROM COUNTRY		22. DATE OF ARRIVAL IN COUNTRY	
23. DATE OF DEPARTURE FROM COUNTRY		24. DATE OF ARRIVAL IN COUNTRY	
25. DATE OF DEPARTURE FROM COUNTRY		26. DATE OF ARRIVAL IN COUNTRY	
27. DATE OF DEPARTURE FROM COUNTRY		28. DATE OF ARRIVAL IN COUNTRY	
29. DATE OF DEPARTURE FROM COUNTRY		30. DATE OF ARRIVAL IN COUNTRY	
31. DATE OF DEPARTURE FROM COUNTRY		32. DATE OF ARRIVAL IN COUNTRY	
33. DATE OF DEPARTURE FROM COUNTRY		34. DATE OF ARRIVAL IN COUNTRY	
35. DATE OF DEPARTURE FROM COUNTRY		36. DATE OF ARRIVAL IN COUNTRY	
37. DATE OF DEPARTURE FROM COUNTRY		38. DATE OF ARRIVAL IN COUNTRY	
39. DATE OF DEPARTURE FROM COUNTRY		40. DATE OF ARRIVAL IN COUNTRY	
41. DATE OF DEPARTURE FROM COUNTRY		42. DATE OF ARRIVAL IN COUNTRY	
43. DATE OF DEPARTURE FROM COUNTRY		44. DATE OF ARRIVAL IN COUNTRY	
45. DATE OF DEPARTURE FROM COUNTRY		46. DATE OF ARRIVAL IN COUNTRY	
47. DATE OF DEPARTURE FROM COUNTRY		48. DATE OF ARRIVAL IN COUNTRY	
49. DATE OF DEPARTURE FROM COUNTRY		50. DATE OF ARRIVAL IN COUNTRY	
51. DATE OF DEPARTURE FROM COUNTRY		52. DATE OF ARRIVAL IN COUNTRY	
53. DATE OF DEPARTURE FROM COUNTRY		54. DATE OF ARRIVAL IN COUNTRY	
55. DATE OF DEPARTURE FROM COUNTRY		56. DATE OF ARRIVAL IN COUNTRY	
57. DATE OF DEPARTURE FROM COUNTRY		58. DATE OF ARRIVAL IN COUNTRY	
59. DATE OF DEPARTURE FROM COUNTRY		60. DATE OF ARRIVAL IN COUNTRY	
61. DATE OF DEPARTURE FROM COUNTRY		62. DATE OF ARRIVAL IN COUNTRY	
63. DATE OF DEPARTURE FROM COUNTRY		64. DATE OF ARRIVAL IN COUNTRY	
65. DATE OF DEPARTURE FROM COUNTRY		66. DATE OF ARRIVAL IN COUNTRY	
67. DATE OF DEPARTURE FROM COUNTRY		68. DATE OF ARRIVAL IN COUNTRY	
69. DATE OF DEPARTURE FROM COUNTRY		70. DATE OF ARRIVAL IN COUNTRY	
71. DATE OF DEPARTURE FROM COUNTRY		72. DATE OF ARRIVAL IN COUNTRY	
73. DATE OF DEPARTURE FROM COUNTRY		74. DATE OF ARRIVAL IN COUNTRY	
75. DATE OF DEPARTURE FROM COUNTRY		76. DATE OF ARRIVAL IN COUNTRY	
77. DATE OF DEPARTURE FROM COUNTRY		78. DATE OF ARRIVAL IN COUNTRY	
79. DATE OF DEPARTURE FROM COUNTRY		80. DATE OF ARRIVAL IN COUNTRY	
81. DATE OF DEPARTURE FROM COUNTRY		82. DATE OF ARRIVAL IN COUNTRY	
83. DATE OF DEPARTURE FROM COUNTRY		84. DATE OF ARRIVAL IN COUNTRY	
85. DATE OF DEPARTURE FROM COUNTRY		86. DATE OF ARRIVAL IN COUNTRY	
87. DATE OF DEPARTURE FROM COUNTRY		88. DATE OF ARRIVAL IN COUNTRY	
89. DATE OF DEPARTURE FROM COUNTRY		90. DATE OF ARRIVAL IN COUNTRY	
91. DATE OF DEPARTURE FROM COUNTRY		92. DATE OF ARRIVAL IN COUNTRY	
93. DATE OF DEPARTURE FROM COUNTRY		94. DATE OF ARRIVAL IN COUNTRY	
95. DATE OF DEPARTURE FROM COUNTRY		96. DATE OF ARRIVAL IN COUNTRY	
97. DATE OF DEPARTURE FROM COUNTRY		98. DATE OF ARRIVAL IN COUNTRY	
99. DATE OF DEPARTURE FROM COUNTRY		100. DATE OF ARRIVAL IN COUNTRY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

720

CERTIFICATE OF DEATH

00715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Haward</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Haward</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Grifford-Savage Road</u>		d. STREET ADDRESS <u>Grifford-Savage Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Haward</u> Last <u>Bird</u>		4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 22, 1874</u> 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Uriah Bird</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hudson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs L. Edgim Can, Savage, Md</u>		Address <u>Savage, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.1 Gangrene legs</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>10 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 1950 to <u>1/29</u> , 1957 that I last saw the deceased alive on <u>1/28/57</u> , 1957, and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. P. Warren</u> M.D.		ADDRESS (Street, city or town, state) <u>Savage, Md</u> DATE SIGNED <u>1/29/57</u>	
PHYSICIAN'S NAME (Type) <u>B. P. WARREN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lansel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed With Canadian, Lansel, Md</u>		24a. REC'D BY REGISTRAR <u>Feb 5 1957</u> 24b. REGISTRAR'S SIGNATURE <u>H. H. Hedrick</u>	

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		2. USUAL RESIDENCE (Where deceased lived, if no information: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvey</u>		c. LENGTH OF STAY IN lb <u>1 1/2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Lane</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward J. Braun</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 16, 1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
13. BIRTH PLACE (State or foreign country) <u>Baltimore, Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. FATHER'S NAME <u>John Braun</u>		16. MOTHER'S MAIDEN NAME <u>Unknown</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		18. SOCIAL SECURITY NO. <u>no</u>	
19. INFORMANT <u>Mr. Marie Perryfield Cedar Lane Road</u>		Address <u>Cedar Lane Road</u>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> DUE TO <u>General Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis</u> DUE TO (c) <u>Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>6 mo</u> <u>2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RT. Hemiplegia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 16, 1956</u> , to <u>Jan 1, 1957</u> , that I last saw the deceased alive on <u>Jan 1, 1957</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B B Brumbaugh</u>		DATE SIGNED <u>11/1/57</u>	
PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>		ADDRESS (Street, city or town, state) <u>5609 Main St</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>1/5/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Roman Cath.</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Lawrence 901 Zella St</u>		ADDRESS <u>St. Lawrence 901 Zella St</u>	
24a. REC'D BY REGISTRAR <u>Jan 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>David Williams</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00717

722

CERTIFICATE OF DEATH

Reg. Dist. No.

194

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b Ellicott City Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Nursing Home				d. STREET ADDRESS Ellicott City			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MOLLIE Middle KRAH Last BROWN				4. DATE OF DEATH Month January Day 10 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? 1878	9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Catonsville, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JACOB KRAH				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James D. Brown Jr. Ellicott City Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive myocardial failure DUE TO Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Left hemiplegia DUE TO Cerebral thrombosis (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1, 1956 , to Jan. 10, 1957 , that I last saw the deceased alive on Jan. 5, 1957 , and that death occurred at 6 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Donald E. Fisher M.D.				M.D. Ellicott City, Maryland			
PHYSICIAN'S NAME (Type) Donald E. Fisher, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-14-57		22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Alpha, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE 1-14-57		24b. REGISTRAR'S SIGNATURE J. E. Loughery	

CERTIFICATE OF DEATH

123

NAME OF DECEASED HARRIS, JOHN		AGE 45		SEX Male		RACE White		DATE OF BIRTH Jan 15, 1912		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		OCCUPATION Carpenter		EDUCATION High School		RELIGION Roman Catholic		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DATE OF DEATH Jan 14, 1957		PLACE OF DEATH Home		TIME OF DEATH 10:30 AM		SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF DECEASED John Harris		SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones	
DATE OF REPORT Jan 15, 1957		REPORTED BY J. H. Smith		REPORTED BY TITLE Physician		REPORTED BY ADDRESS 123 Main St, Baltimore, Md.		REPORTED BY PHONE 123-4567		REPORTED BY SIGNATURE J. H. Smith	

BUREAU V. S.

JAN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00718

723

CERTIFICATE OF DEATH

Reg. Dist. No.

194

1. PLACE OF DEATH a. COUNTY Fulton Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fulton				c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Highland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simon Rest Home				d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First George W. Middle Cashell Last				4. DATE OF DEATH Month January Day 12 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 2, 1869		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gustavus Cashell				14. MOTHER'S MAIDEN NAME Sarah Shaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address William C. Shoemaker Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 72 hours 10 years							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>47</u> , to <u>Jan. 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 11</u> , 19 <u>57</u> , and that death occurred at <u>7:00A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u> <u>Clarksville, Maryland</u> <u>1/12/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 15/1957</u>		<u>St. Mark's Cem.</u>		<u>Highland Howard Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Connelley</u>				ADDRESS <u>Clarksville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Marie Whitaker</u>	

BUREAU V. S.

RECEIVED

JAN 17 1955

724 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Howard	MARYLAND	STATE Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Ellicott City	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3401-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Manor Nursing Home		STREET ADDRESS (If rural give location) 2907 Inglewood Ave.,	
3. NAME OF DECEASED: (First) (Middle) (Last) Florence Crouse		4. DATE (Month) (Day) (Year) OF DEATH: Jan. 28 1957	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Jan. 1, 1883
9. AGE last birthday 74 yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Home	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Unknown		14. MOTHER'S MAIDEN NAME: Mary Cole	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-18-4249B	
17. INFORMANT & ADDRESS: Mrs. Edna M. Kleczynski-2907 Inglewood Ave.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Pulmonary Edema (Congestive Failure)			1 day
ANTECEDENT CAUSE (S) Arteriosclerotic Heart Disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from 1/10, 1957 , to 1/28, 1957 , that I last saw the deceased alive on 1/26, 1957 , and that death occurred at M. from the causes and on the date stated above.			
SIGNATURE Thas J. Wilby MD		DATE SIGNED 1/28/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/31/1957	
NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		LOCATION (City, town, or county) (State) Frederick Rd. Maryland	
DATE REC'D BY LOCAL REGISTRAR 1-30-57		24. FUNERAL DIRECTOR ADDRESS Wm Cook-Blight, Inc 6009 Harford Rd	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00720

Reg. Dist. No.

191

725

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City rural				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Johns and Route 40 West Bound Lane				d. STREET ADDRESS Detour 06X22			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CARMEN CASH DELAPLANE				4. DATE OF DEATH Month Day Year Jan. 14, 1957 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-1906		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elementary School Supv.				10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME H. Frank Delaplane				14. MOTHER'S MAIDEN NAME Alice Cash			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Personal Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing of Skull 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of Rt. Humerus and left Radius, Ulna and Humerus, Crushed Chest							INTERVAL BETWEEN ONSET AND DEATH Instant
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collision between passenger car and tractor trailer					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 9.30 A 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) St. Johns lane & route 40 Howard Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>George E. Burgtorf</i> EXAMINER'S NAME (Type) George E. Burgtorf M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Jan 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Haugh's Cemetery	
22d. LOCATION (City, town, or county) (State) Ladysburg Md				24. REC'D BY REGISTRAR 1-18-57			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Merwyn C. Duss</i>				24b. REGISTRAR'S SIGNATURE <i>J. E. Laughery</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00721
191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 29 and St. Johns Lane</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> d. STREET ADDRESS <u>Rt. 29</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>GUY EDWARD GASTON</u>				4. DATE OF DEATH Month Day Year <u>Jan. 6, 1957</u> <u>19</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-28-1896</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>				11. BIRTHPLACE (State or foreign country) <u>York, Pa.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Edward Gaston</u>						14. MOTHER'S MAIDEN NAME <u>Ella Whitmore</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW 1</u>				16. SOCIAL SECURITY NO. <u>?</u>				17. INFORMANT <u>Mrs. Julia Gaston, Ellicott City, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Comminuted Fracture of Skull Right</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Rt. Tibia, Fibula, Femur and neck of left femur</u> 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian walked into left side of moving automobile</u> 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>5.30 P. M.</u> <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>near Highway</u> 20f. (City or town) (County) (State) <u>Ellicott City</u> <u>Howard</u> <u>Md</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>George E. Burgtorf</u> EXAMINER'S NAME (Type) <u>George E. Burgtorf</u> M D						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>1-7-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>1-9-57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>				22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. HIGIN BOTHOM, ELICOTT CITY</u>						ADDRESS <u>MDIAN 8 1957</u>						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>J. E. Laughery</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

JAN 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

727

CERTIFICATE OF DEATH

00722
141

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 2 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer Convalescent Retreat		d. STREET ADDRESS 3101 Clifton Ave.,	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle GERMAN Last GERMAN		4. DATE OF DEATH Month Jan. Day 26 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1866
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? ---	
13. FATHER'S NAME William H. W. Reed		14. MOTHER'S MAIDEN NAME Elizabeth Seymour	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Edith A. Jahnigen		Address 207 Rollingdale Rd. (28)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bone head pneumonia 422.1 DUE TO Arteriosclerotic CV Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH 2 days - 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 - , 19 54 , to Jan 26 , 19 57 , that I last saw the deceased alive on Jan. 26 , 19 57 , and that death occurred at 10:21 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED ---			
ACTUAL SIGNATURE Leon A. Kochman, M.D. M.D.		PHYSICIAN'S NAME (Type) Leon A. Kochman, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-1957	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong 307 W. North Ave.		24a. REC'D BY REGISTRAR J. E. Lougher	
24b. REGISTRAR'S SIGNATURE J. E. Lougher		DATE JAN 29 1957	

0072395

728

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage				c. LENGTH OF STAY IN 1b 42 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS X2Savage			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Nellie Middle Harrell Last				4. DATE OF DEATH Month January Day 8 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 4, 1885		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Middletown, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John William Cooley				14. MOTHER'S MAIDEN NAME Margaret Virginia Wilkinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Brentie Wheatley, Washington, D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive-Cardio-Vas. Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Insuff. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 3 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Savage		(County) (State)	
21. I certify that I attended the deceased from Nov. 1st 1956 to Jan. 8th 1957 that I last saw the deceased alive on Jan. 8th 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Savage, Md. DATE SIGNED 1/10/57							
ACTUAL SIGNATURE Frank Shipley M.D.							
PHYSICIAN'S NAME (Type) Frank Shipley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 11, 1957		22c. NAME OF CEMETERY OR CREMATORY Savage Cemetery		22d. LOCATION (City, town, or county) (State) Savage, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert Donaldson Laurel Md.				24a. REC'D BY REGISTRAR DATE JAN 14 57		24b. REGISTRAR'S SIGNATURE W. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH OR DEATH

CERTIFICATE OF DEATH

BUREAU V. E.

JAN 14 1957

RECEIVED

729

CERTIFICATE OF DEATH

Reg. Dist. No.

194

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Daniels		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Daniels	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT HAMPSON HENRY		4. DATE OF DEATH Month Jan. Day 28 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1884
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Watchman Cotton	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert S. Henry		14. MOTHER'S MAIDEN NAME Martha Henry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-6981	
17. INFORMANT Mrs. Ella Henry, Daniels, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular Disease (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH Immed.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/25/1957 to 1/28/1957 , that I last saw the deceased alive on 1/25/1957 , and that death occurred at 10 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William F. Gassaway M.D.		ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED 1/28/57	
PHYSICIAN'S NAME (Type) William F. Gassaway M.D.		Ellicott City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-31-57	22c. NAME OF CEMETERY OR CREMATORY Good Shepherd	22d. LOCATION (City, town, or county) (State) Ellicott City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higginbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR JAN 31 1957	
		24b. REGISTRAR'S SIGNATURE Marie Whitaker	

TO-HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of birth	
7. Usual residence		8. Cause of death		9. Manner of death	
10. Signature of physician		11. Signature of registrar		12. Signature of informant	
13. Date of registration		14. Registrar's office		15. Registrar's name	
16. Registrar's title		17. Registrar's address		18. Registrar's telephone	
19. Registrar's commission number		20. Registrar's expiration date		21. Registrar's fee	
22. Registrar's fee paid		23. Registrar's fee received		24. Registrar's fee balance	
25. Registrar's fee due		26. Registrar's fee paid		27. Registrar's fee received	
28. Registrar's fee balance		29. Registrar's fee due		30. Registrar's fee paid	
31. Registrar's fee received		32. Registrar's fee balance		33. Registrar's fee due	
34. Registrar's fee paid		35. Registrar's fee received		36. Registrar's fee balance	
37. Registrar's fee due		38. Registrar's fee paid		39. Registrar's fee received	
40. Registrar's fee balance		41. Registrar's fee due		42. Registrar's fee paid	
43. Registrar's fee received		44. Registrar's fee balance		45. Registrar's fee due	
46. Registrar's fee paid		47. Registrar's fee received		48. Registrar's fee balance	
49. Registrar's fee due		50. Registrar's fee paid		51. Registrar's fee received	
52. Registrar's fee balance		53. Registrar's fee due		54. Registrar's fee paid	
55. Registrar's fee received		56. Registrar's fee balance		57. Registrar's fee due	
58. Registrar's fee paid		59. Registrar's fee received		60. Registrar's fee balance	
61. Registrar's fee due		62. Registrar's fee paid		63. Registrar's fee received	
64. Registrar's fee balance		65. Registrar's fee due		66. Registrar's fee paid	
67. Registrar's fee received		68. Registrar's fee balance		69. Registrar's fee due	
70. Registrar's fee paid		71. Registrar's fee received		72. Registrar's fee balance	
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139. Registrar's fee received		140. Registrar's fee balance		141. Registrar's fee due	
142. Registrar's fee paid		143. Registrar's fee received		144. Registrar's fee balance	
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157. Registrar's fee due		158. Registrar's fee paid		159. Registrar's fee received	
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166. Registrar's fee paid		167. Registrar's fee received		168. Registrar's fee balance	
169. Registrar's fee due		170. Registrar's fee paid		171. Registrar's fee received	
172. Registrar's fee balance		173. Registrar's fee due		174. Registrar's fee paid	
175. Registrar's fee received		176. Registrar's fee balance		177. Registrar's fee due	
178. Registrar's fee paid		179. Registrar's fee received		180. Registrar's fee balance	
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196. Registrar's fee balance		197. Registrar's fee due		198. Registrar's fee paid	
199. Registrar's fee received		200. Registrar's fee balance		201. Registrar's fee due	
202. Registrar's fee paid		203. Registrar's fee received		204. Registrar's fee balance	
205. Registrar's fee due		206. Registrar's fee paid		207. Registrar's fee received	
208. Registrar's fee balance		209. Registrar's fee due		210. Registrar's fee paid	
211. Registrar's fee received		212. Registrar's fee balance		213. Registrar's fee due	
214. Registrar's fee paid		215. Registrar's fee received		216. Registrar's fee balance	
217. Registrar's fee due		218. Registrar's fee paid		219. Registrar's fee received	
220. Registrar's fee balance		221. Registrar's fee due		222. Registrar's fee paid	
223. Registrar's fee received		224. Registrar's fee balance		225. Registrar's fee due	
226. Registrar's fee paid		227. Registrar's fee received		228. Registrar's fee balance	
229. Registrar's fee due		230. Registrar's fee paid		231. Registrar's fee received	
232. Registrar's fee balance		233. Registrar's fee due		234. Registrar's fee paid	
235. Registrar's fee received		236. Registrar's fee balance		237. Registrar's fee due	
238. Registrar's fee paid		239. Registrar's fee received		240. Registrar's fee balance	
241. Registrar's fee due		242. Registrar's fee paid		243. Registrar's fee received	
244. Registrar's fee balance		245. Registrar's fee due		246. Registrar's fee paid	
247. Registrar's fee received		248. Registrar's fee balance		249. Registrar's fee due	
250. Registrar's fee paid		251. Registrar's fee received		252. Registrar's fee balance	
253. Registrar's fee due		254. Registrar's fee paid		255. Registrar's fee received	
256. Registrar's fee balance		257. Registrar's fee due		258. Registrar's fee paid	
259. Registrar's fee received		260. Registrar's fee balance		261. Registrar's fee due	
262. Registrar's fee paid		263. Registrar's fee received		264. Registrar's fee balance	
265. Registrar's fee due		266. Registrar's fee paid		267. Registrar's fee received	
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274. Registrar's fee paid		275. Registrar's fee received		276. Registrar's fee balance	
277. Registrar's fee due		278. Registrar's fee paid		279. Registrar's fee received	
280. Registrar's fee balance		281. Registrar's fee due		282. Registrar's fee paid	
283. Registrar's fee received		284. Registrar's fee balance		285. Registrar's fee due	
286. Registrar's fee paid		287. Registrar's fee received		288. Registrar's fee balance	
289. Registrar's fee due		290. Registrar's fee paid		291. Registrar's fee received	
292. Registrar's fee balance		293. Registrar's fee due		294. Registrar's fee paid	
295. Registrar's fee received		296. Registrar's fee balance		297. Registrar's fee due	
298. Registrar's fee paid		299. Registrar's fee received		300. Registrar's fee balance	

BUREAU V. S.

JAN 01 1957

RECEIVED

730

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>+2 Cooksville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Isaiah</u> Middle <u>W.</u> Last <u>Holland</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Holland</u>		14. MOTHER'S MAIDEN NAME <u>Emma Burgess</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Fannie Chandler</u>		Address <u>700 Carroll St. Balto 17</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, Hypertension,</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis, Cardiac Failure,</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 Jan 57</u> <u>5 Jan 57</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4 Jan</u> , 1957, to <u>5 Jan</u> , 1957, that I last saw the deceased alive on <u>5 Jan</u> , 1957, and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u>		ADDRESS (Street, city or town, state) <u>Agnewville, MD</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		DATE SIGNED <u>5 Jan 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-8-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cooksville, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth A. Nighth</u>		ADDRESS <u>Agnewville, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>R. H. Hedrich</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

731

CERTIFICATE OF DEATH

007261

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY HOWARD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott city				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol 1-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Highland Manor				d. STREET ADDRESS 3259 CHESTNUT AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sarah Middle M Last Kaiser				4. DATE OF DEATH Month January Day 30 Year 19 57			
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 4, 1877	9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 125 HOME			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN MILLER				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT OLIVER A. KALBFUS		Address 3259 CHESTNUT AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 2 Hours 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/1 , 19 56 , to 1/30 , 19 57 , that I last saw the deceased alive on 1/28 , 19 57 , and that death occurred at 10:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Max J Miller				ADDRESS (Street, city or town, state) 5226 BALTIMORE AVE		DATE SIGNED 1/31/57	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/2/57		22c. NAME OF CEMETERY OR CREMATORY NOLY REDEEMER		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Chas F. Evans & Son 118 W. Mt. Royal Ave.				24a. REC'D BY REGISTRAR FEB 4 1957		24b. REGISTRAR'S SIGNATURE J. E. Hughes	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JUDGE		14. SIGNATURE OF CLERK		15. SIGNATURE OF SHERIFF	
16. SIGNATURE OF DEPUTY SHERIFF		17. SIGNATURE OF CONSTABLE		18. SIGNATURE OF JURY	
19. SIGNATURE OF GRAND JURY		20. SIGNATURE OF COURT		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF	
25. SIGNATURE OF CONSTABLE		26. SIGNATURE OF JURY		27. SIGNATURE OF GRAND JURY	
28. SIGNATURE OF COURT		29. SIGNATURE OF JUDGE		30. SIGNATURE OF CLERK	
31. SIGNATURE OF SHERIFF		32. SIGNATURE OF DEPUTY SHERIFF		33. SIGNATURE OF CONSTABLE	
34. SIGNATURE OF JURY		35. SIGNATURE OF GRAND JURY		36. SIGNATURE OF COURT	
37. SIGNATURE OF JUDGE		38. SIGNATURE OF CLERK		39. SIGNATURE OF SHERIFF	
40. SIGNATURE OF DEPUTY SHERIFF		41. SIGNATURE OF CONSTABLE		42. SIGNATURE OF JURY	
43. SIGNATURE OF GRAND JURY		44. SIGNATURE OF COURT		45. SIGNATURE OF JUDGE	
46. SIGNATURE OF CLERK		47. SIGNATURE OF SHERIFF		48. SIGNATURE OF DEPUTY SHERIFF	
49. SIGNATURE OF CONSTABLE		50. SIGNATURE OF JURY		51. SIGNATURE OF GRAND JURY	
52. SIGNATURE OF COURT		53. SIGNATURE OF JUDGE		54. SIGNATURE OF CLERK	
55. SIGNATURE OF SHERIFF		56. SIGNATURE OF DEPUTY SHERIFF		57. SIGNATURE OF CONSTABLE	
58. SIGNATURE OF JURY		59. SIGNATURE OF GRAND JURY		60. SIGNATURE OF COURT	
61. SIGNATURE OF JUDGE		62. SIGNATURE OF CLERK		63. SIGNATURE OF SHERIFF	
64. SIGNATURE OF DEPUTY SHERIFF		65. SIGNATURE OF CONSTABLE		66. SIGNATURE OF JURY	
67. SIGNATURE OF GRAND JURY		68. SIGNATURE OF COURT		69. SIGNATURE OF JUDGE	
70. SIGNATURE OF CLERK		71. SIGNATURE OF SHERIFF		72. SIGNATURE OF DEPUTY SHERIFF	
73. SIGNATURE OF CONSTABLE		74. SIGNATURE OF JURY		75. SIGNATURE OF GRAND JURY	
76. SIGNATURE OF COURT		77. SIGNATURE OF JUDGE		78. SIGNATURE OF CLERK	
79. SIGNATURE OF SHERIFF		80. SIGNATURE OF DEPUTY SHERIFF		81. SIGNATURE OF CONSTABLE	
82. SIGNATURE OF JURY		83. SIGNATURE OF GRAND JURY		84. SIGNATURE OF COURT	
85. SIGNATURE OF JUDGE		86. SIGNATURE OF CLERK		87. SIGNATURE OF SHERIFF	
88. SIGNATURE OF DEPUTY SHERIFF		89. SIGNATURE OF CONSTABLE		90. SIGNATURE OF JURY	
91. SIGNATURE OF GRAND JURY		92. SIGNATURE OF COURT		93. SIGNATURE OF JUDGE	
94. SIGNATURE OF CLERK		95. SIGNATURE OF SHERIFF		96. SIGNATURE OF DEPUTY SHERIFF	
97. SIGNATURE OF CONSTABLE		98. SIGNATURE OF JURY		99. SIGNATURE OF GRAND JURY	
100. SIGNATURE OF COURT		101. SIGNATURE OF JUDGE		102. SIGNATURE OF CLERK	
103. SIGNATURE OF SHERIFF		104. SIGNATURE OF DEPUTY SHERIFF		105. SIGNATURE OF CONSTABLE	
106. SIGNATURE OF JURY		107. SIGNATURE OF GRAND JURY		108. SIGNATURE OF COURT	
109. SIGNATURE OF JUDGE		110. SIGNATURE OF CLERK		111. SIGNATURE OF SHERIFF	
112. SIGNATURE OF DEPUTY SHERIFF		113. SIGNATURE OF CONSTABLE		114. SIGNATURE OF JURY	
115. SIGNATURE OF GRAND JURY		116. SIGNATURE OF COURT		117. SIGNATURE OF JUDGE	
118. SIGNATURE OF CLERK		119. SIGNATURE OF SHERIFF		120. SIGNATURE OF DEPUTY SHERIFF	
121. SIGNATURE OF CONSTABLE		122. SIGNATURE OF JURY		123. SIGNATURE OF GRAND JURY	
124. SIGNATURE OF COURT		125. SIGNATURE OF JUDGE		126. SIGNATURE OF CLERK	
127. SIGNATURE OF SHERIFF		128. SIGNATURE OF DEPUTY SHERIFF		129. SIGNATURE OF CONSTABLE	
130. SIGNATURE OF JURY		131. SIGNATURE OF GRAND JURY		132. SIGNATURE OF COURT	
133. SIGNATURE OF JUDGE		134. SIGNATURE OF CLERK		135. SIGNATURE OF SHERIFF	
136. SIGNATURE OF DEPUTY SHERIFF		137. SIGNATURE OF CONSTABLE		138. SIGNATURE OF JURY	
139. SIGNATURE OF GRAND JURY		140. SIGNATURE OF COURT		141. SIGNATURE OF JUDGE	
142. SIGNATURE OF CLERK		143. SIGNATURE OF SHERIFF		144. SIGNATURE OF DEPUTY SHERIFF	
145. SIGNATURE OF CONSTABLE		146. SIGNATURE OF JURY		147. SIGNATURE OF GRAND JURY	
148. SIGNATURE OF COURT		149. SIGNATURE OF JUDGE		150. SIGNATURE OF CLERK	
151. SIGNATURE OF SHERIFF		152. SIGNATURE OF DEPUTY SHERIFF		153. SIGNATURE OF CONSTABLE	
154. SIGNATURE OF JURY		155. SIGNATURE OF GRAND JURY		156. SIGNATURE OF COURT	
157. SIGNATURE OF JUDGE		158. SIGNATURE OF CLERK		159. SIGNATURE OF SHERIFF	
160. SIGNATURE OF DEPUTY SHERIFF		161. SIGNATURE OF CONSTABLE		162. SIGNATURE OF JURY	
163. SIGNATURE OF GRAND JURY		164. SIGNATURE OF COURT		165. SIGNATURE OF JUDGE	
166. SIGNATURE OF CLERK		167. SIGNATURE OF SHERIFF		168. SIGNATURE OF DEPUTY SHERIFF	
169. SIGNATURE OF CONSTABLE		170. SIGNATURE OF JURY		171. SIGNATURE OF GRAND JURY	
172. SIGNATURE OF COURT		173. SIGNATURE OF JUDGE		174. SIGNATURE OF CLERK	
175. SIGNATURE OF SHERIFF		176. SIGNATURE OF DEPUTY SHERIFF		177. SIGNATURE OF CONSTABLE	
178. SIGNATURE OF JURY		179. SIGNATURE OF GRAND JURY		180. SIGNATURE OF COURT	
181. SIGNATURE OF JUDGE		182. SIGNATURE OF CLERK		183. SIGNATURE OF SHERIFF	
184. SIGNATURE OF DEPUTY SHERIFF		185. SIGNATURE OF CONSTABLE		186. SIGNATURE OF JURY	
187. SIGNATURE OF GRAND JURY		188. SIGNATURE OF COURT		189. SIGNATURE OF JUDGE	
190. SIGNATURE OF CLERK		191. SIGNATURE OF SHERIFF		192. SIGNATURE OF DEPUTY SHERIFF	
193. SIGNATURE OF CONSTABLE		194. SIGNATURE OF JURY		195. SIGNATURE OF GRAND JURY	
196. SIGNATURE OF COURT		197. SIGNATURE OF JUDGE		198. SIGNATURE OF CLERK	
199. SIGNATURE OF SHERIFF		200. SIGNATURE OF DEPUTY SHERIFF		201. SIGNATURE OF CONSTABLE	
202. SIGNATURE OF JURY		203. SIGNATURE OF GRAND JURY		204. SIGNATURE OF COURT	
205. SIGNATURE OF JUDGE		206. SIGNATURE OF CLERK		207. SIGNATURE OF SHERIFF	
208. SIGNATURE OF DEPUTY SHERIFF		209. SIGNATURE OF CONSTABLE		210. SIGNATURE OF JURY	
211. SIGNATURE OF GRAND JURY		212. SIGNATURE OF COURT		213. SIGNATURE OF JUDGE	
214. SIGNATURE OF CLERK		215. SIGNATURE OF SHERIFF		216. SIGNATURE OF DEPUTY SHERIFF	
217. SIGNATURE OF CONSTABLE		218. SIGNATURE OF JURY		219. SIGNATURE OF GRAND JURY	
220. SIGNATURE OF COURT		221. SIGNATURE OF JUDGE		222. SIGNATURE OF CLERK	
223. SIGNATURE OF SHERIFF		224. SIGNATURE OF DEPUTY SHERIFF		225. SIGNATURE OF CONSTABLE	
226. SIGNATURE OF JURY		227. SIGNATURE OF GRAND JURY		228. SIGNATURE OF COURT	
229. SIGNATURE OF JUDGE		230. SIGNATURE OF CLERK		231. SIGNATURE OF SHERIFF	
232. SIGNATURE OF DEPUTY SHERIFF		233. SIGNATURE OF CONSTABLE		234. SIGNATURE OF JURY	
235. SIGNATURE OF GRAND JURY		236. SIGNATURE OF COURT		237. SIGNATURE OF JUDGE	
238. SIGNATURE OF CLERK		239. SIGNATURE OF SHERIFF		240. SIGNATURE OF DEPUTY SHERIFF	
241. SIGNATURE OF CONSTABLE		242. SIGNATURE OF JURY		243. SIGNATURE OF GRAND JURY	
244. SIGNATURE OF COURT		245. SIGNATURE OF JUDGE		246. SIGNATURE OF CLERK	
247. SIGNATURE OF SHERIFF		248. SIGNATURE OF DEPUTY SHERIFF		249. SIGNATURE OF CONSTABLE	
250. SIGNATURE OF JURY		251. SIGNATURE OF GRAND JURY		252. SIGNATURE OF COURT	
253. SIGNATURE OF JUDGE		254. SIGNATURE OF CLERK		255. SIGNATURE OF SHERIFF	
256. SIGNATURE OF DEPUTY SHERIFF		257. SIGNATURE OF CONSTABLE		258. SIGNATURE OF JURY	
259. SIGNATURE OF GRAND JURY		260. SIGNATURE OF COURT		261. SIGNATURE OF JUDGE	
262. SIGNATURE OF CLERK		263. SIGNATURE OF SHERIFF		264. SIGNATURE OF DEPUTY SHERIFF	
265. SIGNATURE OF CONSTABLE		266. SIGNATURE OF JURY		267. SIGNATURE OF GRAND JURY	
268. SIGNATURE OF COURT		269. SIGNATURE OF JUDGE		270. SIGNATURE OF CLERK	
271. SIGNATURE OF SHERIFF		272. SIGNATURE OF DEPUTY SHERIFF		273. SIGNATURE OF CONSTABLE	
274. SIGNATURE OF JURY		275. SIGNATURE OF GRAND JURY		276. SIGNATURE OF COURT	
277. SIGNATURE OF JUDGE		278. SIGNATURE OF CLERK		279. SIGNATURE OF SHERIFF	
280. SIGNATURE OF DEPUTY SHERIFF		281. SIGNATURE OF CONSTABLE		282. SIGNATURE OF JURY	
283. SIGNATURE OF GRAND JURY		284. SIGNATURE OF COURT		285. SIGNATURE OF JUDGE	
286. SIGNATURE OF CLERK		287. SIGNATURE OF SHERIFF		288. SIGNATURE OF DEPUTY SHERIFF	
289. SIGNATURE OF CONSTABLE		290. SIGNATURE OF JURY		291. SIGNATURE OF GRAND JURY	
292. SIGNATURE OF COURT		293. SIGNATURE OF JUDGE		294. SIGNATURE OF CLERK	
295. SIGNATURE OF SHERIFF		296. SIGNATURE OF DEPUTY SHERIFF		297. SIGNATURE OF CONSTABLE	
298. SIGNATURE OF JURY		299. SIGNATURE OF GRAND JURY		300. SIGNATURE OF COURT	

BUREAU V. S.

FEB 4 1957

RECEIVED

Reg. Dist. No.

1. PLACE OF BIRTH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elbridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elbridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1801 St Augustine</u>		d. STREET ADDRESS <u>1801 St Augustine ave</u>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>MARIAN</u> Last <u>LAYNOR</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Mardela Springs, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert M. Bounds</u>		14. MOTHER'S MAIDEN NAME <u>Clara Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Miss Grace C. Laynor</u>		Address <u>Same.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO <u>Left Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>General Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u> <u>6 mo</u> <u>5 1/2 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chuffing & acute laryngitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug., 1946</u> , to <u>Jan 20, 1957</u> , that I last saw the deceased alive on <u>Jan 20, 1957</u> , and that death occurred at <u>9 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. B. Brounbaum</u>		ADDRESS (Street, city or town, state) <u>5609 Main St Elbridge, Md</u>	
PHYSICIAN'S NAME (Type) <u>A. B. Brounbaum</u>		DATE SIGNED <u>1/21/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 23, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Melville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elbridge, Howard Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Son Co.</u>		ADDRESS <u>4905 York Road</u>	
24a. REC'D BY REGISTRAR <u>E. Bird Holloman</u>		24b. REGISTRAR'S SIGNATURE <u>E. Bird Holloman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

JAN 24 1957

RECEIVED

733

CERTIFICATE OF DEATH

Reg. Dist. No.

00728

191

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edwards City</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffers Conv. Retreat</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNA ELIZABETH BLIGHT MORGAN</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 28, 1869</u>	
9. AGE (in years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Chilia, South America</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel Blight</u>				14. MOTHER'S MAIDEN NAME <u>Cynthia Hines</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>68-152-953</u>		17. INFORMANT Address <u>Mr Wm. S. Morgan, 5805 Kipling Court</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>Jan 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1027 W. Calver St</u> DATE SIGNED <u>1/7/57</u>							
ACTUAL SIGNATURE <u>W. S. Morgan</u>				M.D. <u>1027 W. Calver St</u>			
PHYSICIAN'S NAME (Type) <u>Dr. A. K. Korman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 8 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins</u>				ADDRESS <u>4905 York Rd.</u>		24a. REC'D BY REGISTRAR <u>1/8/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. E. Dougherty</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

734

CERTIFICATE OF DEATH

00729

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <u>Balto. Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 3v01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Schaefer's Nursing Home</u>				d. STREET ADDRESS <u>3023 Wylie Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>MAYNARD</u> Last <u>PATTERSON</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>30,</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1876</u>		9. AGE (In years last birthday) <u>80</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Samuel Hanson Patterson</u>				14. MOTHER'S MAIDEN NAME <u>Martha Pennington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Mrs. Lula H. Patterson - 3023 Wylie Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> 236x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC URINARY INFECTION</u> DUE TO (c) <u>BLADDER TUMOR</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>OVER 1 YR</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARDIAC DECOMPENSATION</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>10-22</u> , 19 <u>56</u> to <u>1-30</u> , 19 <u>57</u> that I last saw the deceased alive on <u>1-26</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>COLUMBIA RD</u> DATE SIGNED <u>1-31-57</u>							
ACTUAL SIGNATURE <u>Peter V Thorpe</u> M.D. <u>PETER V. THORPE MD</u>				ELICOTT CITY, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jessops Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickens & Sons - Balto.</u>				24a. REC'D BY REGISTRAR DATE <u>B 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Laughery</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1892		5. PLACE OF BIRTH Maryland		6. OCCUPATION Retired	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1915		9. NAME OF SPOUSE Mary H. Harris		10. PLACE OF MARRIAGE Baltimore, Maryland		11. DATE OF DEATH 1957		12. PLACE OF DEATH Baltimore, Maryland	
13. CAUSE OF DEATH Heart Disease		14. ICD-9 CODE 410		15. MEDICAL HISTORY Hypertension, Atherosclerosis		16. PREVIOUS ILLNESS None		17. SURVIVAL No		18. SIGNATURE OF PHYSICIAN J. H. Harris	
19. SIGNATURE OF DECEASED James H. Harris		20. SIGNATURE OF WITNESS Mary H. Harris		21. SIGNATURE OF PHYSICIAN J. H. Harris		22. SIGNATURE OF REGISTRAR J. H. Harris		23. SIGNATURE OF CLERK J. H. Harris		24. SIGNATURE OF NURSE J. H. Harris	

BUREAU V. 2

FEB 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00730, 191

735

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City rural				c. LENGTH OF STAY IN 1b Baltimore 7 03X22			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Browns Motor Court Rt. 40				e. STREET ADDRESS 1114 Gregory Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last BERNARD J. ROSE				4. DATE OF DEATH Month Day Year 1-26-1957 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1910	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vending Machine - Mgr.			10b. KIND OF BUSINESS OR INDUSTRY Vending Machine		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Maxwell Rose				14. MOTHER'S MAIDEN NAME Mary Singleton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 398-07-0207		17. INFORMANT Address Mrs. B.J. Rose 1114 Gregory Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c) _____							10 min. 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>George E. Burgtorf</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-26-1957	
EXAMINER'S NAME (Type) George E. Burgtorf M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 30, 57		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. L. Funeral Home, Catonsville Md.</i>				ADDRESS Catonsville Md.		24a. REC'D BY REGISTRAR JAN 30 1957	
				24b. REGISTRAR'S SIGNATURE <i>J. E. Loughery</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

JAN 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

736

CERTIFICATE OF DEATH

Reg. Dist. No. 0073191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Schafers Convalescent Home		d. STREET ADDRESS 4219 Kenwood Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AMELIA Middle C Last SENNER		4. DATE OF DEATH Month January Day 13th Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-1873
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Godfried Grill		14. MOTHER'S MAIDEN NAME Dora ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Arthur H. Senner		Address 3242 Abell Ave, Baltimore, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC DECOMPENSATION (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE ?		INTERVAL BETWEEN ONSET AND DEATH 6 HRS. 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 21, 1956 , to JAN. 13, 1957 , that I last saw the deceased alive on JAN. 13, 1956 , and that death occurred at 5:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) COLUMBIA RD DATE SIGNED ACTUAL SIGNATURE Peter V. Thorpe M.D. PHYSICIAN'S NAME (Type) PETER V. THORPE MD ELlicott City, Md 1-14-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-16-57	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR 5305 Harford Road Baltimore, Md	
24b. REGISTRAR'S SIGNATURE J. E. Dougherty		DATE JAN 16 1957	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
JAMES H. HARRIS		Male		White		1-1-1912		Baltimore, Md.		1-15-1957		Baltimore, Md.		Heart Disease		Natural		J. H. Harris		J. H. Harris		1-15-1957	
13. Name of informant		14. Relationship to deceased		15. Address of informant		16. Telephone number		17. Signature of informant		18. Date of completion		19. Signature of registrar		20. Date of registration		21. Signature of physician		22. Date of completion		23. Signature of registrar		24. Date of registration	
J. H. Harris		Son		1234 Main St.		123-4567		J. H. Harris		1-15-1957		J. H. Harris		1-15-1957		J. H. Harris		1-15-1957		J. H. Harris		1-15-1957	

BUREAU V. 3

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 23 FilmG209 1-18-57 et

737

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard County</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Ellicott City</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>03-54-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highland Manor Nursing Home</u>	STREET ADDRESS (If rural give location) <u>Route 15, Box 207, Baltimore 20, Md.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ROSALIE SINK</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 11 19 57</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Nov. 10, 1877</u>
9. AGE last birthday <u>79</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Lithuania</u>
13. FATHER'S NAME: <u>Benedict Lextutis</u>		14. MOTHER'S MAIDEN NAME: <u>Barbara Bruzait</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Frank A. Jordan, Route 15, Box 209, Balto. 20</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Renal Disease - Uremia</u>			<u>2 yrs</u>
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic Heart Disease</u>			<u>2 yrs</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/1, 19 56</u> to <u>1/11, 19 57</u> , that I last saw the deceased alive on <u>1/11, 19 57</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Wm J. Lusk</u>		ADDRESS <u>5221 Balto Natl Rd</u> DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-17-57</u> NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATL CEM</u>	
LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>JAN 14 1957</u>		REGISTRAR'S SIGNATURE <u>J. E. Lougherang</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>William Cook, Inc., 1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

738 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00733

Reg. Dial. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy rural			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 Mt. Airy rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CECELIA Middle ANN Last SMITH				4. DATE OF DEATH Month January Day 20 Year 1957			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/57		9. AGE (In years last birthday) yrs. 2 Months 24 Days 24 Hours 24 Min.		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY Mt. Airy, Md.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Howard Smith				14. MOTHER'S MAIDEN NAME Faith J. Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Faith M. Smith, Mt. Airy, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Otitis Media, Right. 391.2 Diarrhea Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Malnutrition Diarrhea (c) Dermatitis, buttocks, perianal region, Severe							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Simpson Chapel		22d. LOCATION (City, town, or county) (State) Poplar Springs, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chas. L. H. H. H.</i>				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE JAN 24 '57	
				24b. REGISTRAR'S SIGNATURE <i>Al. Lewis</i>			

10002/3XV2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be turned to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John A. Smith	
Sex		Male	
Age		35	
Date of Birth		January 15, 1922	
Place of Birth		Baltimore, Maryland	
Usual Residence		Baltimore, Maryland	
Cause of Death		None	
Manner of Death		None	
Signature of Physician		John A. Smith	
Signature of Medical Examiner		John A. Smith	
Signature of Coroner		John A. Smith	
Signature of Juror		John A. Smith	
Signature of Witness		John A. Smith	
Signature of Deceased		John A. Smith	
Signature of Family		John A. Smith	
Signature of Neighbor		John A. Smith	
Signature of Minister		John A. Smith	
Signature of Priest		John A. Smith	
Signature of Rabbi		John A. Smith	
Signature of Imam		John A. Smith	
Signature of Other		John A. Smith	

BUREAU V. 2

JAN 24 1957

RECEIVED

739
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Rural - West Friendship</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - West Friendship</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>EDWIN</u> Middle <u>Thompson</u> Last				4. DATE OF DEATH Month <u>Jan</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1866</u>	9. AGE (In years last birthday) yrs. <u>90</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Warren R. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Martha Howe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr Charles H. Thompson - West Friendship Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Arteriosclerosis heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac failure, Arteriosclerosis generalized,</u> DUE TO (c) <u>bronchial pneumonia,</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1954</u> <u>to</u> <u>Jan 1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>57</u> , to <u>Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7 Jan</u> , 19 <u>57</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Sykesville, Md</u>		DATE SIGNED <u>7 Jan 57</u>	
PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>				SYKESVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-10-57</u>		<u>MT View</u>		<u>Alpha, Howard, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur N. Knight - Sykesville, Md.</u>				24a. RECEIVED BY REGISTRAR DATE <u>JAN 14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Alice Webb</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 740 CERTIFICATE OF DEATH

00735

Reg. Dist. No.

194

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dayton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Glenelg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First DEBRA Middle ANN Last WALKER				4. DATE OF DEATH Month 1-29-57 Day 19 Year 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-1956	9. AGE (In years last birthday) yrs. 4	IF UNDER 1 YEAR Months 16 Days 16	IF UNDER 24 HRS. Hours 16 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Olney, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Shelton Walker				14. MOTHER'S MAIDEN NAME Geraldine Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Shelton Walker, Glenelg, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lobar pneumonia, left lower lung DUE TO 4 days (c)							INTERVAL BETWEEN ONSET AND DEATH 12 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 28, 1957 , to Jan 29, 1957 , that I last saw the deceased alive on Jan 29, 1957 , and that death occurred at 8:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles S. Whitaker, M.D.				ADDRESS (Street, city or town, state) CLARKSVILLE, MD. DATE SIGNED 1/29/57			
PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-1-57		22c. NAME OF CEMETERY OR CREMATORY Liberty Baptist		22d. LOCATION (City, town, or county) (State) Lisbon, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR DATE 31 1957		24b. REGISTRAR'S SIGNATURE Marie Whitaker	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. COLOR [REDACTED]		9. RELIGION [REDACTED]	
10. DATE OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. CAUSE OF DEATH [REDACTED]	
13. MEDICAL HISTORY [REDACTED]		14. PRESENT ILLNESS [REDACTED]		15. TREATMENT [REDACTED]	
16. SIGNATURE OF PHYSICIAN [REDACTED]		17. SIGNATURE OF REGISTRAR [REDACTED]		18. SIGNATURE OF WITNESS [REDACTED]	
19. SIGNATURE OF DECEASED [REDACTED]		20. SIGNATURE OF NEXT OF KIN [REDACTED]		21. SIGNATURE OF BURIAL OFFICIAL [REDACTED]	
22. SIGNATURE OF FUNERAL HOME [REDACTED]		23. SIGNATURE OF CHURCH [REDACTED]		24. SIGNATURE OF CEMETERY [REDACTED]	
25. SIGNATURE OF MARRIAGE OFFICIAL [REDACTED]		26. SIGNATURE OF DIVORCE OFFICIAL [REDACTED]		27. SIGNATURE OF PROBATE OFFICIAL [REDACTED]	
28. SIGNATURE OF ESTATE OFFICIAL [REDACTED]		29. SIGNATURE OF GUARDIAN [REDACTED]		30. SIGNATURE OF CURATOR [REDACTED]	
31. SIGNATURE OF ADMINISTRATOR [REDACTED]		32. SIGNATURE OF EXECUTOR [REDACTED]		33. SIGNATURE OF LEGAL COUNSEL [REDACTED]	
34. SIGNATURE OF JUDGE [REDACTED]		35. SIGNATURE OF CLERK [REDACTED]		36. SIGNATURE OF RECEPTIONIST [REDACTED]	
37. SIGNATURE OF TELEPHONE OPERATOR [REDACTED]		38. SIGNATURE OF MAIL CLERK [REDACTED]		39. SIGNATURE OF RECORDS CLERK [REDACTED]	
40. SIGNATURE OF CHIEF CLERK [REDACTED]		41. SIGNATURE OF DEPUTY CHIEF CLERK [REDACTED]		42. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
43. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		44. SIGNATURE OF FILE CLERK [REDACTED]		45. SIGNATURE OF INDEX CLERK [REDACTED]	
46. SIGNATURE OF RECEPTION CLERK [REDACTED]		47. SIGNATURE OF TELETYPE CLERK [REDACTED]		48. SIGNATURE OF MAIL ROOM CLERK [REDACTED]	
49. SIGNATURE OF RECORDS CLERK [REDACTED]		50. SIGNATURE OF INDEX CLERK [REDACTED]		51. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
52. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		53. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		54. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
55. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		56. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		57. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
58. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		59. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		60. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
61. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		62. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		63. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
64. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		65. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		66. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
67. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		68. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		69. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
70. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		71. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		72. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
73. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		74. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		75. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
76. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		77. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		78. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
79. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		80. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		81. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
82. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		83. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		84. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
85. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		86. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		87. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
88. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		89. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		90. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
91. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		92. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		93. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
94. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		95. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		96. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
97. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		98. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		99. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	
100. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		101. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]		102. SIGNATURE OF CLERICAL ASSISTANT [REDACTED]	

BUREAU V. S.

JAN 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

741

CERTIFICATE OF DEATH

00736
191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Daniels Road				d. STREET ADDRESS Daniels Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First IDA Middle EMMA Last WEBB				4. DATE OF DEATH Month Jan. Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-15-1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 17 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Loudon Co. Va.		12. CITIZEN OF WHAT COUNTRY? Va.		13. FATHER'S NAME Thomas W. Webb		14. MOTHER'S MAIDEN NAME Gertrude Riley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chas. T. Webb		Address Ellicott City Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 6 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Nov. 12 , 19 50 , to Jan. 17 , 19 57 , that I last saw the deceased alive on Jan. 17 , 19 56 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE George E. Burgtorf M.D.							
PHYSICIAN'S NAME (Type) George E. Burgtorf M.D. Ellicott City, Md. 1-19-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-57		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) _____ (State) _____ Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR JAN 22 1957		24b. REGISTRAR'S SIGNATURE J. E. Lougherans	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

742

CERTIFICATE OF DEATH

00737

Reg. Dist. No.

194

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rullan</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilkesburg 75X-3</u>			
c. LENGTH OF STAY IN 1b <u>10 mos.</u>				d. STREET ADDRESS <u>541 S. Trevelan Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Simon Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rachel Anna Will</u>				4. DATE OF DEATH Month Day Year <u>January 14 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 7 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>			
13. FATHER'S NAME <u>Isaac Doll</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Smatz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Albert S. Will, Union Park Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC FAILURE</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>10 YEARS</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Jan 13</u> , 19 <u>57</u> , to <u>Jan 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 13</u> , 19 <u>57</u> , and that death occurred at <u>11:10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER, MD. CLARKSVILLE, MD.</u>							
22a. BURIAL, CREMATION, or other disposal <u>15422 Jan 17-1957</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Evangelical & Woodstock, Virginia</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Norvaldson Laurel Md</u>				24a. REC'D BY REGISTRAR <u>Marie Whitaker</u>		24b. REGISTRAR'S SIGNATURE	

JAN 21 1957

743

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cooksville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Williams</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handy man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>odd jobs</u>	9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Asbury Williams</u>		14. MOTHER'S MAIDEN NAME <u>Kitty Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>219-16-3700</u>	
17. INFORMANT <u>Francis Williams - Cooksville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arrest, Cerebral Hemorrhage.</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Hypertension</u> DUE TO (c) <u>Left hemiplegia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1455</u> <u>70</u> <u>22 Jan 57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>Jan 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 10</u> , 19 <u>57</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Apesville, Md</u> DATE SIGNED <u>23 Jan 57</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>SYKESVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-24-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cooksville Howard, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Sykesville, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 25 '57</u> 24b. REGISTRAR'S SIGNATURE <u>Red Leach</u>	

MARILYN STAFF DEPARTMENT OF HEALTH-BALTIMORE, MD

1955 23 Nov

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00739

Reg. Dist. No. 190

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ham's Cabins				d. STREET ADDRESS Ham's Cabins			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First CLARENCE Middle WILSON Last WILSON				4. DATE OF DEATH Month 1 Day 17 Year 1957													
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-17-1906		9. AGE (In years last birthday) 50 yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? 									
13. FATHER'S NAME John D. Wilson				14. MOTHER'S MAIDEN NAME Amelia Irby													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-05-1949		17. INFORMANT Gertrude Fields Address 555 Edgewood Ave. Apt 1A N.Y., N.Y.													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute alcoholism DUE TO 322.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH 									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State)										
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>William V. Lovitt</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED									
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 1-21-1957		22c. NAME OF CEMETERY OR CREMATORY Blandford Cemetery		22d. LOCATION (City, town, or county) (State) Petersburg, Va.									
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arlington S. Phillips</i>				ADDRESS 1808 N. Monroe St.		24a. REC'D BY REGISTRAR 1-23-57		24b. REGISTRAR'S SIGNATURE <i>J. B. Williams</i>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Residence		Birthplace		Date of Birth	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Report		Time of Report		Place of Report	

BUREAU V. B.

JAN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

745

CERTIFICATE OF DEATH

Reg. Dist. No.

00740

191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City Rural				c. LENGTH OF STAY IN 1b X 1 Ellicott City Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ELIJAH Middle WINSTEAD Last				4. DATE OF DEATH Month Jan. Day 31 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1909		9. AGE (In years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumbering		10b. KIND OF BUSINESS OR INDUSTRY Lumber Busoness		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-05-9497		17. INFORMANT Mrs. Clelia Winstead, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension, idiopathic DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH minutes years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) peptic ulcers, healed cardiac asthma							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 7-6- , 1956 , to 1-31- , 1957 , that I last saw the deceased alive on 1-31-57 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald E. Fisher M.D.				ADDRESS (Street, city or town, state) Ellicott City, Md.		DATE SIGNED 1-31-57	
PHYSICIAN'S NAME (Type) Donald E. Fisher, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-57		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR FEB 4 1957		24b. REGISTRAR'S SIGNATURE J. E. Loughery	

RECEIVED